

6807

## CERTIFICATE OF DEATH

06791

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>ALBRIGHT</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/25/1907</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BREAD PACKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>Margaret WHITSEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-18-1012</b>		17. INFORMANT <b>MR. HARRY A. ALBRIGHT</b> Address <b>HAGERSTOWN RT. #5</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>chr. glomerular nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular hypertension</b> DUE TO (c) <b>acute cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>17 yrs</b> <b>4 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 <b>57</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>HAGERSTOWN</b>				20g. (County) <b>MD.</b>		20h. (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>Oct 1947</b> , to <b>June 18 1957</b> , that I last saw the deceased alive on <b>June 18 1957</b> , and that death occurred at <b>7:30 P M</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>				DATE SIGNED <b>6-19-57</b>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>							
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMAINS (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Thormont</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 22, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

JUN 25 1957

RECEIVED

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06792

6808

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. # 6</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>FRANCES</u> Last <u>ARTHUR</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 6, 1870</u>	9. AGE (In years last birthday) <u>86 yrs.</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Chewsville, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Gimple</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rhodnizer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. H. Edwin Semler Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>6 Jun</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 Jun</u> , 19 <u>57</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eldon G. Hoachlander</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>115 W. WASHINGTON STREET</u> <u>HAGERSTOWN, MARYLAND</u> <u>6/7/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ringer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 10, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF DECEASED [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF WITNESS [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF WITNESS [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF WITNESS [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF WITNESS [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF WITNESS [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF WITNESS [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF WITNESS [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF WITNESS [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF WITNESS [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF WITNESS [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF WITNESS [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF WITNESS [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF WITNESS [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF WITNESS [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF WITNESS [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF WITNESS [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF WITNESS [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF WITNESS [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF WITNESS [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF WITNESS [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF WITNESS [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF WITNESS [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU V. 2

JUN 12 1957

RECEIVED



6809

# CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>25 1/2 W. Franklin St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Betty</b>		First <b>Rebecca</b>		Middle <b>Baker</b>		Last	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1955</b>	
				9. AGE (In years last birthday) <b>21 mos.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>infant</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson C. Baker</b>				14. MOTHER'S MAIDEN NAME <b>Betty Jane House</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Betty Jane House Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Mental + Developmental Retardation</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/19/57</b> to <b>6/20/57</b> , that I last saw the deceased alive on <b>6/19/57</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. M. Bacon Jr.</b>		DATE SIGNED <b>6/24/57</b>					
PHYSICIAN'S NAME (Type) <b>DR. A. M. BACON, JR.</b>		<b>HAGERSTOWN Md.</b>					
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. S.

JUN 27 1957

RECEIVED

6862

## CERTIFICATE OF DEATH

06794

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEITERSBURG</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REEDERS NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH MAY BAKER</b>				4. DATE OF DEATH Month Day Year <b>JUNE 23 1957 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7 1871</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LEITERSBURG WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ROBERT E. SLACK</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA RIDENOUR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. VIRGIE A. DEAN HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-renal vascular disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>teeth cellulitis of left jaw</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>1 wk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 5</b> , 19 <b>57</b> , to <b>June 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>57</b> , and that death occurred at <b>10 PM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> DATE SIGNED <b>6/24/57</b>							
ACTUAL SIGNATURE <b>G. W. LeVan</b>				M.D. <b>Boonsboro Md.</b>			
PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 25 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REFORMED CEMETERY LEITERSBURG WASH. CO. MD.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul J. H. Hager</b>				24a. REC'D BY REGISTRAR <b>June 25, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bart</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 6810  
 CERTIFICATE OF DEATH

06795

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Banks, Sr.		4. DATE OF DEATH Month June Day 28 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY W. Maryland R.R.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Banks		14. MOTHER'S MAIDEN NAME Elizabeth Bull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harry W. Banks, Jr., 201 Kuethe Rd, Glen Burnie, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x General arteriosclerosis & cerebral thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Severe hypertensive vascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 weeks 10-15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610x Benign prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/15/56, 19, to 6/28/57, 19, that I last saw the deceased alive on 6/28/57, 19, and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Dittott, M.D.		ADDRESS (Street, city or town, state) 212 W. Washington St. DATE SIGNED 6/28/57	
PHYSICIAN'S NAME (Type) Edward W. Dittott, M.D.		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-2-57	22c. NAME OF CEMETERY OR CREMATORY Morraine Mausoleum	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR 2 1957 24b. REGISTRAR'S SIGNATURE Chas. J. Bowles	



RECEIVED

1957 2 JUL

6811

CERTIFICATE OF DEATH

06796

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>				c. LENGTH OF STAY IN 1b <u>3 WKS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>918 E. Preston</u> <u>3v01-4</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Jane</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.7.1881</u>		9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator Shoe Mactory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fulton County Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Jane A Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-3861</u>		17. INFORMANT <u>Jessie E McCusker Little Orleans Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary carcinoma of the liver with metastasis</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u> <u>Thrombophlebitis, femoral veins, bilateral</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 13, 1957</u> to <u>June 3, 1957</u> , that I last saw the deceased alive on <u>June 2, 1957</u> , and that death occurred at <u>4:25 a M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Clear Spring, Md.</u> <u>June 4, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.6.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Little Orleans Allegany Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Jones</u>				ADDRESS <u>Harwood, Md.</u>		24a. REC'D BY REGISTRAR <u>June 6, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>			

**BUREAU V. S.**

1957 10 NOV

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

6812

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>15 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 Cypress St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KARL</b> Middle <b>NEWTON</b> Last <b>BEARD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 18 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Letter Carrier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Chewsville Wash. Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Silas Beard</b>				14. MOTHER'S MAIDEN NAME <b>Clara Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Don Z. Beard Hagerstown Md. R # 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertensive Vascular Disease</b> 447x				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 yrs.</b> <b>7 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>447x</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Washington</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 22</b> , 19 <b>57</b> to <b>June 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>57</b> , and that death occurred at <b>9 A.</b> -M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St. - Hagerstown, Md.</b> DATE SIGNED <b>7/24/57</b>							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>				PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 26 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED J. Edgar Hoover		DATE OF BIRTH Jan 22 1895		PLACE OF BIRTH Albany, New York	
RESIDENCE Washington, D.C.		DATE OF DEATH Jan 26 1957		PLACE OF DEATH Washington, D.C.	
OCCUPATION Director, Federal Bureau of Investigation		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
EDUCATION Bachelor of Science, University of Virginia		DATE OF INTERMENT Jan 28 1957		PLACE OF INTERMENT Arlington National Cemetery	
RELIGION Roman Catholic		DATE OF BURIAL Jan 28 1957		PLACE OF BURIAL Arlington National Cemetery	
MARRIAGE Married		DATE OF MARRIAGE Jan 22 1917		PLACE OF MARRIAGE Washington, D.C.	
FAMILY HISTORY None		DATE OF LAST ILLNESS Jan 22 1957		PLACE OF LAST ILLNESS Washington, D.C.	
DATE OF DEATH Jan 26 1957		TIME OF DEATH 10:15 AM		PLACE OF DEATH Washington, D.C.	
DATE OF INTERMENT Jan 28 1957		TIME OF INTERMENT 10:15 AM		PLACE OF INTERMENT Arlington National Cemetery	
DATE OF BURIAL Jan 28 1957		TIME OF BURIAL 10:15 AM		PLACE OF BURIAL Arlington National Cemetery	
DATE OF LAST ILLNESS Jan 22 1957		TIME OF LAST ILLNESS 10:15 AM		PLACE OF LAST ILLNESS Washington, D.C.	
DATE OF MARRIAGE Jan 22 1917		TIME OF MARRIAGE 10:15 AM		PLACE OF MARRIAGE Washington, D.C.	
DATE OF INTERMENT Jan 28 1957		TIME OF INTERMENT 10:15 AM		PLACE OF INTERMENT Arlington National Cemetery	
DATE OF BURIAL Jan 28 1957		TIME OF BURIAL 10:15 AM		PLACE OF BURIAL Arlington National Cemetery	

BUREAU V. S.

JUN 26 1957

RECEIVED



6813

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carlock Memorial Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RENA</u> Middle <u>ELIZABETH</u> Last <u>BECK</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 11, 1980</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick County, Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Margaret Randall</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiac-vascular</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>disease with cardiac decompensation</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr 10, 1957</u> , to <u>June 22, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>2<sup>00</sup></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				ADDRESS (Street, city or town, state) <u>317 W. Washington St</u>		DATE SIGNED <u>6/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>				<u>Hagerstown, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Pomeroy</u>				24a. REC'D BY REGISTRAR <u>June 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
CITY		COUNTY	
STATE		ZIP CODE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

JUN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pen Mar		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Pen Mar	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Junior Beckwith		4. DATE OF DEATH Month Day Year June 21 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1932
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army - Soldier		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Beckwith		14. MOTHER'S MAIDEN NAME Hazel Hollenshead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mr. John F. Beckwith- Pen Mar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x Gun Shot wound thru chest into heart DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self thru chest into heart ( 22 claibre )	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 7:00 x June 21 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) Pen Mar (County) Wash (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-57	
22c. NAME OF CEMETERY OR CREMATORY Upperton Cemetery		22d. LOCATION (City, town, or county) Upperton, Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter F. Hure		24a. REC'D BY REGISTRAR JUN 25 1957	
ADDRESS Waynesboro, Pa.		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

1957 25 NTH

RECEIVED

6814

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>45 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carlock Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Rebecca</u> Last <u>Beery</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1872</u>	
9. AGE (In years last birthday) <u>84 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Linville, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Col. Emanuel Sipe</u>		14. MOTHER'S MAIDEN NAME <u>Penelope Jennings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>C. Lynwood Beery, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Senile + Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 9</u> , 19 <u>57</u> , to <u>June 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>57</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>159 W. Washington St., Hagerstown, Maryland</u> <u>6/3/57</u> ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St. Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Kruger</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>June 3, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair C. Bowers</u>			



BUREAU V. 3

JUN 12 1957

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JUN 12 1951

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6815

# CERTIFICATE OF DEATH

06801

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>50YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JACKSON CONV. HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
f. STREET ADDRESS <b>1916 VIRGINIA AVE.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>HAZEL</b> Last <b>BOWMAN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/26/1889</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>KNEPPER</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA MOWEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. MARGUERITE BOYER HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>6 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1<sup>st</sup> 1955</b> to <b>June 21 1957</b> , that I last saw the deceased alive on <b>June 21 1957</b> , and that death occurred at <b>9 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6-22-57</b>							
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Paul Harrison M. D., 318 N. Potomac St., Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. J. Normant, Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Brown</b>	



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06802

6816

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>155 Elizabeth Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Ambroggio Britti</u>				4. DATE OF DEATH Month Day Year <u>June 12 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 15, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>4 27</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Work</u>		11. BIRTHPLACE (State or foreign country) <u>Reggio Callabero Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italian</u>							
13. FATHER'S NAME <u>Ambroggio Britti</u>				14. MOTHER'S MAIDEN NAME <u>Francesca Tripodo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-3790</u>		17. INFORMANT <u>Mr. Tony Britti</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 W</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/11/57</u> , 19 <u>57</u> , to <u>6/12/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/12/57</u> , 19 <u>57</u> , and that death occurred at <u>12 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Vh Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>145 W Washington St</u> DATE SIGNED <u>6/12/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. h. Campbell</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rager</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>June 15, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>			

BUREAU V. 8

JUN 18 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film 217, 6/21/57 fcy

Item 12

6817

CERTIFICATE OF DEATH

06803

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>				c. LENGTH OF STAY IN 1b <b>11 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>455 N. Jonathan Street</b>				d. STREET ADDRESS <b>455 N. Jonathan Street.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Cheston</b> Middle <b>Hamilton</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 8 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Shepherdstown, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George W. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wagner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Cera Keys 455 N. Jonathan Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 14th, 1946</b> , to <b>June 14th, 1957</b> , that I last saw the deceased alive on <b>June 14th, 1957</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St.</b> DATE SIGNED <b>6/15/57</b>							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				M.D. <b>159 W. Washington St.</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shepherdstown W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr Hagerstown Md</b>				24. REC'D BY REGISTRAR <b>June 17 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shasta Bowers</b>	

**BUREAU V. S.**

JUN 19 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 16 RURAL and give nearest town <u>FOUR MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>JACKSON CONValescent HOME</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JULIA</u> Last <u>BURNER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>- 8 -</u> Year <u>19 57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 17 - 1881</u>	
9. AGE (In years last birthday) <u>75-7-21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ST. JAMES WASH. Co. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>ALICE HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>JACOB H. BURNER</u> Address <u>BOONSBORO MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast &amp; metastases</u> <u>170X</u> DUE TO <u>to spine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 years</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/28 19 56</u> , to <u>6/8, 19 57</u> , that I last saw the deceased alive on <u>7/16, 19 57</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				<u>154 West Washington St.,</u> <u>6:10:57</u>			
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JUNE 11-1957</u>		<u>BOONSBORO CEMETERY</u>		<u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONSBORO MD.</u>				24. REC'D BY REGISTRAR <u>JUN 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hornbaker</u>	

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be filed with the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF CORONER</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF BURIAL PLACE</p>		<p>19. SIGNATURE OF INTERMENT</p>		<p>20. SIGNATURE OF RECORDS</p>	

BUREAU V. S.

JUN 17 1957

RECEIVED

6819

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>27 yrs.</b>		d. STREET ADDRESS <b>417 Belview Ave.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>417 Belview Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Ann</b> Last <b>Bush</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-1-1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Roanoke, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry E. Caldwell</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>James H. Bush</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of spine + pelvis</b> <b>1999</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases from unknown site.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 June, 1957</b> , to <b>12 June, 1957</b> , that I last saw the deceased alive at <b>(not seen alive)</b> and that death occurred at <b>3:05 PM</b> from the causes and on the date stated above. <b>(Family M.H. Outgown)</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>Richard T. Binford</b> <b>14 June 57</b>			
ACTUAL SIGNATURE M.D.		PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b> <b>1135 POTOMAC AVENUE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>6-15-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	22d. LOCATION (City, town, or county) (State) <b>Roanoke Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 15, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06806

305

6864

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bbonsboro</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
f. STREET ADDRESS <b>921 Washington Ave</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>ELSIE</b> Last <b>BUSSARD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Startzman</b>		14. MOTHER'S MAIDEN NAME <b>Ida Zimmerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Pearl Martin</b>		Address <b>921 Washington Ave Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Poly Arthritis</b> (c) <b>Poly Arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>725x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1-57</b> to <b>6-17-57</b> , that I last saw the deceased alive on <b>6-17-57</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. E. W. Dittus</b>		DATE SIGNED <b>6/17/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dittus</b>		M.D. <b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 20, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Best</b>	

# CERTIFICATE OF DEATH

THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

AND

DEPARTMENT OF LABOR

DEPARTMENT OF AGRICULTURE

DEPARTMENT OF COMMERCE

DEPARTMENT OF EDUCATION

DEPARTMENT OF FINANCE

DEPARTMENT OF GENERAL SERVICES

DEPARTMENT OF HUMAN RESOURCES

DEPARTMENT OF JUSTICE

DEPARTMENT OF LAND AND NATURAL RESOURCES

DEPARTMENT OF MILITARY AND NAVAL AFFAIRS

DEPARTMENT OF PUBLIC SAFETY

DEPARTMENT OF REVENUE

DEPARTMENT OF TRANSPORTATION

DEPARTMENT OF UTILITIES

DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF WORKERS COMPENSATION

DEPARTMENT OF WILDLIFE AND PARKS

DEPARTMENT OF ZONING

DEPARTMENT OF

BUREAU V. E.

JUN 19 1957

RECEIVED

*[Handwritten signatures and stamps, including "RECEIVED" and "JUN 19 1957"]*

## CERTIFICATE OF DEATH

06807

Reg. Dist. No. 302

6820

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1237 Potomac Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MURIEL LILLIE CALHOUN</u>		4. DATE OF DEATH Month Day Year <u>June 28 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>2 6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Germantown, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Carrie M. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-36-0823</u>	
17. INFORMANT <u>William C. Calhoun</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphogenous leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1957</u> to <u>July 2, 1957</u> , that I last saw the deceased alive on <u>July 2, 1957</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hagerstown, Md. July 2, 1957</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>July 2, 1957</u>	
PHYSICIAN'S NAME (Type) <u>V. B. Beckley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Pryor</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 3

JUL 5 1967

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6865**  
**CERTIFICATE OF DEATH**

06810

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>			c. LENGTH OF STAY IN 1b <u>months</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>			d. STREET ADDRESS <u>Middletown 10x22</u>		
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Keffer</u> Last <u>Crone</u>			4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>carpentry</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Charles M. Crone</u>			14. MOTHER'S MAIDEN NAME <u>Mary C. Biser</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-7644</u>	17. INFORMANT <u>Mrs. Agnes Mullen, Middletown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>57</u> , to <u>June 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 14</u> , 19____, and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. Elmer Harp</u>			ADDRESS (Street, city or town, state) <u>Middletown 6-15-57</u>		
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>			<u>Middletown, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/16/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUNE 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Burt</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06811

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penna b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle 75x-3 ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 19 N. Carlisle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First May Middle Ione Last Diehl				4. DATE OF DEATH Month June Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. Scott Fleming				14. MOTHER'S MAIDEN NAME May Byrant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Mrs. John L. Ritchy - Greencastle, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd & 3rd degree burns of face, neck, torso, 9 hrs DUE TO both thighs. Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently caught fire while smoking in the bathroom					
20c. TIME OF INJURY Month, Day, Year Hour 6:30 P.M. June 11 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bathroom-Home		20f. (City or town) (County) (State) Greencastle Franklin Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 11 '57			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Greencastle, Franklin, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. M... Greencastle Pa June 12, 1957				ADDRESS per CRM		24b. REGISTRAR'S SIGNATURE B. H. B...	

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF TOWNSHIP CLERK		19. SIGNATURE OF COUNTY CLERK		20. SIGNATURE OF STATE CLERK	
21. SIGNATURE OF VICE CLERK		22. SIGNATURE OF DEPUTY CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF RECORDS CLERK		25. SIGNATURE OF CHIEF CLERK	
26. SIGNATURE OF DEPUTY CHIEF CLERK		27. SIGNATURE OF CLERK IN CHARGE		28. SIGNATURE OF CLERK IN CHARGE		29. SIGNATURE OF CLERK IN CHARGE		30. SIGNATURE OF CLERK IN CHARGE	
31. SIGNATURE OF CLERK IN CHARGE		32. SIGNATURE OF CLERK IN CHARGE		33. SIGNATURE OF CLERK IN CHARGE		34. SIGNATURE OF CLERK IN CHARGE		35. SIGNATURE OF CLERK IN CHARGE	
36. SIGNATURE OF CLERK IN CHARGE		37. SIGNATURE OF CLERK IN CHARGE		38. SIGNATURE OF CLERK IN CHARGE		39. SIGNATURE OF CLERK IN CHARGE		40. SIGNATURE OF CLERK IN CHARGE	
41. SIGNATURE OF CLERK IN CHARGE		42. SIGNATURE OF CLERK IN CHARGE		43. SIGNATURE OF CLERK IN CHARGE		44. SIGNATURE OF CLERK IN CHARGE		45. SIGNATURE OF CLERK IN CHARGE	
46. SIGNATURE OF CLERK IN CHARGE		47. SIGNATURE OF CLERK IN CHARGE		48. SIGNATURE OF CLERK IN CHARGE		49. SIGNATURE OF CLERK IN CHARGE		50. SIGNATURE OF CLERK IN CHARGE	
51. SIGNATURE OF CLERK IN CHARGE		52. SIGNATURE OF CLERK IN CHARGE		53. SIGNATURE OF CLERK IN CHARGE		54. SIGNATURE OF CLERK IN CHARGE		55. SIGNATURE OF CLERK IN CHARGE	
56. SIGNATURE OF CLERK IN CHARGE		57. SIGNATURE OF CLERK IN CHARGE		58. SIGNATURE OF CLERK IN CHARGE		59. SIGNATURE OF CLERK IN CHARGE		60. SIGNATURE OF CLERK IN CHARGE	
61. SIGNATURE OF CLERK IN CHARGE		62. SIGNATURE OF CLERK IN CHARGE		63. SIGNATURE OF CLERK IN CHARGE		64. SIGNATURE OF CLERK IN CHARGE		65. SIGNATURE OF CLERK IN CHARGE	
66. SIGNATURE OF CLERK IN CHARGE		67. SIGNATURE OF CLERK IN CHARGE		68. SIGNATURE OF CLERK IN CHARGE		69. SIGNATURE OF CLERK IN CHARGE		70. SIGNATURE OF CLERK IN CHARGE	
71. SIGNATURE OF CLERK IN CHARGE		72. SIGNATURE OF CLERK IN CHARGE		73. SIGNATURE OF CLERK IN CHARGE		74. SIGNATURE OF CLERK IN CHARGE		75. SIGNATURE OF CLERK IN CHARGE	
76. SIGNATURE OF CLERK IN CHARGE		77. SIGNATURE OF CLERK IN CHARGE		78. SIGNATURE OF CLERK IN CHARGE		79. SIGNATURE OF CLERK IN CHARGE		80. SIGNATURE OF CLERK IN CHARGE	
81. SIGNATURE OF CLERK IN CHARGE		82. SIGNATURE OF CLERK IN CHARGE		83. SIGNATURE OF CLERK IN CHARGE		84. SIGNATURE OF CLERK IN CHARGE		85. SIGNATURE OF CLERK IN CHARGE	
86. SIGNATURE OF CLERK IN CHARGE		87. SIGNATURE OF CLERK IN CHARGE		88. SIGNATURE OF CLERK IN CHARGE		89. SIGNATURE OF CLERK IN CHARGE		90. SIGNATURE OF CLERK IN CHARGE	
91. SIGNATURE OF CLERK IN CHARGE		92. SIGNATURE OF CLERK IN CHARGE		93. SIGNATURE OF CLERK IN CHARGE		94. SIGNATURE OF CLERK IN CHARGE		95. SIGNATURE OF CLERK IN CHARGE	
96. SIGNATURE OF CLERK IN CHARGE		97. SIGNATURE OF CLERK IN CHARGE		98. SIGNATURE OF CLERK IN CHARGE		99. SIGNATURE OF CLERK IN CHARGE		100. SIGNATURE OF CLERK IN CHARGE	

BUREAU V. S.

JUN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6822

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06812

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1 132 Elm Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HAGERMAN</u> Last <u>DITTO</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1914</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Signal Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Signal Dept.</u>	11. BIRTHPLACE (State or foreign country) <u>Downsville, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Raymond G. Ditto</u>		14. MOTHER'S MAIDEN NAME <u>Ella Downey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Mary C. Ditto</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Electrocuted while sawing bolt on pole near high tension wire</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:40 P. M. June 7 1957</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manor Church Cemetery</u>
		22d. LOCATION (City, town, or county) (State) <u>Tilghmanton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Poyner</u>		24a. REC'D BY REGISTRAR <u>June 10, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

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BUREAU V. S.

JUN 12 1957

RECEIVED

6823

## CERTIFICATE OF DEATH

06813

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>624 W. Franklin</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Marshall Fouché</b>		4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 18, 1881</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>57</b> Min.	
11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Temple Fouché</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Handley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-12-3331</b>		17. INFORMANT <b>Mrs. Jennie Fouché</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO <b>Cerebral Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>19 57</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hagerstown, Md.</b>	
20f. (City or town) <b>Hagerstown</b>		20g. (County) <b>Washington</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>June 1, 1957</b> to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 19, 1957</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>June 21, 1957</b>		22. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	
22d. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		22e. ADDRESS <b>Hagerstown, Md.</b>		22f. REC'D BY REGISTRAR <b>June 24, 1957</b>	
22g. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>		22h. (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED Washington		DATE OF DEATH 7 days		PLACE OF DEATH Washington Co. Hospital	
AGE 7 days		SEX Male		RACE White	
BIRTH DATE July 18, 1941		BIRTH PLACE Washington County, Md.		U.S.A.	
MARRIAGE None		OCCUPATION None		EDUCATION None	
CAUSE OF DEATH Tuberculous meningitis		MANNER OF DEATH Natural		PLACE OF INTERMENT None	
SIGNATURE OF PHYSICIAN J. M. Fouché		SIGNATURE OF REGISTRAR J. M. Fouché		SIGNATURE OF DECEASED None	
DATE OF SIGNATURE July 18, 1941		DATE OF SIGNATURE July 18, 1941		DATE OF SIGNATURE None	
ADDRESS OF DECEASED None		ADDRESS OF PHYSICIAN None		ADDRESS OF REGISTRAR None	
FAMILY HISTORY None		SOCIAL HISTORY None		HISTORICAL DATA None	
LABORATORY DATA None		RADIOLOGICAL DATA None		OTHER DATA None	
PATHOLOGICAL DATA None		TOXICOLOGICAL DATA None		ANTHROPOLOGICAL DATA None	
FORENSIC DATA None		LEGAL DATA None		ADMINISTRATIVE DATA None	
REMARKS None		REMARKS None		REMARKS None	

RECEIVED  
JUN 27 1957  
BUREAU V. S.

Prof. W. Krieger, Hagerstown, Md.

6-12-57

Rose Hill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6824

## CERTIFICATE OF DEATH

06814

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>815 S. POTOMAC ST.</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ROESSNER</b> Last <b>FRENCH</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/1900</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GEORGE I. FRENCH</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE EVERHART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-32-5194</b>		17. INFORMANT <b>MRS. KATHERINE FRENCH</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Lung - R</b> DUE TO (b) <b>lung metastases to mediastinum</b> DUE TO (c) <b>and adrenals</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>Autumn 1956</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>57</b> , to <b>June 24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>57</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D. <b>Sidney Novenstein Md</b> PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/26/ 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county)		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 27, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

WASHINGTON

WASHINGTON

WASHINGTON COUNTY HOSPITAL

612 S. POTOMAC ST.

21111111

GEORGE

ROBBINS

FRENCH

JUNE

8/27/1900

WHITE

BARBER

OWN SHOP

MARYLAND

GEORGE I. FRENCH

CARLIS EVANS

NO

211-22-5124

MRS. KATHARINE FRENCH

BUREAU V. S.

JUL 1 1957

RECEIVED



6866

## CERTIFICATE OF DEATH

06816  
Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u>				c. LENGTH OF STAY IN 1b <u>29 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEMORIAL HOME</u>				d. STREET ADDRESS <u>FAIRFAX STATION</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TRACY - E. GREEN</u>				4. DATE OF DEATH Month Day Year <u>JUNE-14-1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-11-1887</u>	9. AGE (In years last birthday) <u>69-8-3</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HARRISONBURG VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANKLIN B. RODEFEE</u>				14. MOTHER'S MAIDEN NAME <u>EMMA BEERY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS FAHRNEY KEEDY HOME</u> Address <u>BOONSBORO MD</u>		R.2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>June 3</u> , 19 <u>57</u> , to <u>June 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>57</u> , and that death occurred at <u>10:11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Ledan</u> M.D.				ADDRESS (Street, city or town, state) <u>Bonnsboro</u>		DATE SIGNED <u>6/14/57</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Ledan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>WASHINGTON D.C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAMBERS FUNERAL HOME</u> ADDRESS <u>WASHINGTON D.C.</u>				24a. REC'D BY REGISTRAR <u>John H. Post</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARYLAND	
DATE OF DEATH JUNE 19 1957		TIME OF DEATH 10:00 AM	
SEX FEMALE		AGE 78	
RACE WHITE		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JANUARY 1 1879	
NAME OF DECEASED MRS. J. M. SMITH		NAME OF NEXT OF KIN J. M. SMITH	
ADDRESS 1234 E. BALTIMORE AVE.		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
ZIP CODE 21201		SIGNATURE OF DECEASED (None)	
SIGNATURE OF NEXT OF KIN J. M. SMITH		SIGNATURE OF PHYSICIAN DR. J. M. SMITH	
SIGNATURE OF REGISTRAR J. M. SMITH		SIGNATURE OF CLERK J. M. SMITH	

RECEIVED  
 JUN 19 1957  
 BUREAU K. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06818

6825

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>54 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 FAIRGROUND AVE.</b>				d. STREET ADDRESS <b>29 FAIRGROUND AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>PERCY</b>		First <b>MELVILLE</b>		Last <b>HARBAUGH</b>		4. DATE OF DEATH <b>JUNE</b> Month <b>11</b> Day <b>57</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SILK WEAVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RIBBON CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN M. HARBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>MARY M. C. HARBAUGH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-2385</b>		17. INFORMANT <b>MISS EDITH G. HARBAUGH</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertensive, arteriosclerotic Heart Dis</b> DUE TO <b>Generalized arteriosclerosis</b> (c) <b>331X Cardiac failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b> <b>years.</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X Cardiac failure</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 Mar 1957</b> to <b>16 June 1957</b> , that I last saw the deceased alive on <b>10 June 1957</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard T. Binford</b>		M.D. <b>1135 Pittman Ave</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Md</b>		DATE SIGNED <b>11 June 57</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>				ADDRESS <b>Hagerstown, Md</b>		24a. REC'D BY REGISTRAR <b>June 14, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Powers</b>			

RECEIVED

6867

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>San Mar</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick 10x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johny Keedy Memorial Home</u>				d. STREET ADDRESS <u>Boonsboro, Rt 2 Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Harrison</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>June</u> - Day <u>8</u> - Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25 - 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Braddock Fred. Co. Md. U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>James W. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Susan Gibbons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Reade Johny Keedy Memorial Home Boonsboro Md. R. 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Gen</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 6, 1957</u> to <u>June 8, 1957</u> that I last saw the deceased alive on <u>6/6</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>AS 6/11/57</u>							
ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Louis G. Graff M.D. Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boonsboro Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>John H. Pugh</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>June 12, 1957</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 14 1957		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		NONE	
DETAILS OF ILLNESS		PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
HEAVY COLD, BRONCHITIS, PNEUMONIA		NONE		JUN 10 1957		JUN 14 1957		JUN 14 1957		BALTIMORE, MD.	
TREATMENT		HOSPITAL		NAME OF HOSPITAL		DATE OF ADMISSION		DATE OF DISCHARGE		PLACE OF DISCHARGE	
BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		JUN 10 1957		JUN 14 1957		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE		SIGNATURE OF MINISTER		SIGNATURE OF CLERK	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 1

JUN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, a burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Graff

6826

## CERTIFICATE OF DEATH

06820

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 S. Mulberry St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara</u> <u>Alberta</u> <u>Hildebrand</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>2</u> <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frisby Hildebrand</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Funk</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. John Kreglo, 118 S. Mulberry St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vas. Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis gen</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>May 37</u> , 19 <u>57</u> , to <u>June 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis E. Graff</u>				ADDRESS (Street, city or town, state) <u>118 E. Antietam St</u> DATE SIGNED <u>6/3/57</u>			
PHYSICIAN'S NAME (Type) <u>Louis E. GRAFF M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Goffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>June 6, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Brad H. Bowers</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 174 - 1057

## CERTIFICATE OF DEATH

BUREAU V. S.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6868

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06821

Reg. Dist. No.

303

1. PLACE OF DEATH COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Springs</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Frederick</b>				d. STREET ADDRESS <b>1 2111 Virginia Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>NEWTON</b> Last <b>HOFFMAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28 1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>		IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner Green House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ringgold Wash. Co Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Emma M. Leshner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>N. Earl Hoffman 65 East Ave Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Generalized advanced arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>acute coronary occlusion</b> (c) <b>450.0</b> DUE TO <b>acute coronary occlusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> o. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6-19-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro Franklin Co Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 24 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Joseph Murray</b>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JACOB HOLMAN		65		Male		White		May 26 1949		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
1000 North St. Boston, Mass.		None		Heart Disease		Natural		None		None	
FATHER		MOTHER		SIBLINGS		MARRIAGE		EDUCATION		RELIGION	
None		None		None		None		None		None	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS	
None		None		None		None		None		None	
PHYSICIAN		HISTORICAL DATA		LABORATORY DATA		RADIOLOGICAL DATA		PATHOLOGICAL DATA		TOXICOLOGICAL DATA	
None		None		None		None		None		None	

BUREAU V. S.

JUN 24 1957

RECEIVED



6827

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>4 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON CO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>849 GUILFORD AVE.</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>RALPH MARTIN JEFFREY</b>				4. DATE OF DEATH Month Day Year <b>JUNE 7 1957 19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 12 1891</b>	
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PASTOR OF ASSEMBLIES OF GOD CHURCH DARBY PENNA.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>GEORGE B JEFFREY</b>				14. MOTHER'S MAIDEN NAME <b>DIANA HARVEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220 34 2249</b>			
17. INFORMANT <b>MRS. HATTIE JEFFREY HAGERSTOWN MD.</b>				18. ADDRESS <b>849 GUILFORD AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular Disease</b> DUE TO <b>5 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>447X</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2-1-</b> , 19 <b>57</b> , to <b>6-7-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-7-57</b> , 19 <b>57</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. E. W. Dittor</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>6/9/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dittor</b>				ADDRESS <b>Hagerstown Md</b> DATE SIGNED <b>6/9/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 11 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home Boonsboro Md</b>				24. REC'D BY REGISTRAR <b>June 13, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Phyllis Powers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <b>JOHN J. HARRIS</b>		SEX <b>MALE</b>		AGE <b>65</b>		DATE OF BIRTH <b>APR 15 1892</b>	
PLACE OF BIRTH <b>NEW YORK</b>		OCCUPATION <b>LABORER</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>	
RESIDENCE <b>1400 MILLER AVE</b>		DATE OF DEATH <b>JUN 7 1957</b>		PLACE OF DEATH <b>HOSPITAL</b>		DATE OF REPORT <b>JUN 10 1957</b>	
REPORTED BY <b>DR. J. H. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
FAMILY PHYSICIAN <b>DR. J. H. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
CORONER <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
BURIAL PLACE <b>ST. MARY'S CATHEDRAL</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
FURNITURE <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
CLOTHING <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
EFFECTS <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
PROPERTY <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	
OTHER <b>JOHN J. HARRIS</b>		SIGNATURE <i>[Signature]</i>		DATE <b>JUN 10 1957</b>		PLACE <b>BALTIMORE</b>	

BUREAU V. S.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6828

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06823

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EPHRAIM JENNINGS</b>				4. DATE OF DEATH Month Day Year <b>JUNE 28 1957 19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 13 1892 64 yrs.</b>	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMAN B.&amp;O.R.R. FREIGHT STATION BROWNSVILLE WASH.CO.MD.U.S.A.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>EMANUEL JENNINGS</b>				14. MOTHER'S MAIDEN NAME <b>ANGIE BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>705-10-0542</b>		17. INFORMANT Address <b>MRS. NAOMI JENNINGS BROWNSVILLE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>none</b>				20g. (County) <b>none</b>		20h. (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>June 29 '57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 30 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BRETHREN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BROWNSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Paul House Brownsville Wash. Co. Md</b>				ADDRESS <b>June 3, 1957</b>		24. REC'D BY REGISTRAR <b>East Paul House</b>	
24b. REGISTRAR'S SIGNATURE							

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JUL 5 1957

BUREAU V. N.

Form with multiple sections and fields, mostly illegible due to heavy noise and bleed-through. Visible text includes:

- At the top, mirrored text from the reverse side: "MEDICAL EXAMINER'S CERTIFICATE OF DEATH", "STATE OF MARYLAND", "DEPARTMENT OF HEALTH-BALTIMORE 18".
- Section headers: "DEATH CERTIFICATE", "CAUSE OF DEATH", "MANNER OF DEATH", "PLACE OF DEATH", "DATE OF DEATH", "TIME OF DEATH", "AGE", "SEX", "RACE", "RELIGION", "EDUCATION", "OCCUPATION", "MARITAL STATUS", "PREVIOUS ILLNESS", "PREVIOUS SURGERY", "PREVIOUS TRAUMA", "PREVIOUS DRUGS", "PREVIOUS ALCOHOL", "PREVIOUS TOBACCO", "PREVIOUS OTHER".
- Various checkboxes and text boxes for recording medical and personal information.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06824  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Corner of Statford &amp; Marshall Streets</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>MARTIN</u> Last <u>KATZENBERGER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 28, 1954</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Katzenberger</u>		14. MOTHER'S MAIDEN NAME <u>Mae Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Martin Katzenberger</u>		Address <u>Boonsboro Rt 1 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - hemorrhage and shock</u> 824X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a), stating the underlying cause last, (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown out of automobile, striking head on concrete wall</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:10</u> <u>PM</u> June <u>10</u> '57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Hagerstown</u> <u>Wash</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 11 '57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u> <u>P. Frank Rouzer</u>		24. REC'D BY REGISTRAR <u>June 15, 1957</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. Powers</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BANNER 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6830

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06825

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home</u>				d. STREET ADDRESS <u>217 Devonshire Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Othelia</u> Middle <u>-</u> Last <u>Kinslow</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1899</u>		9. AGE (In years last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kulm, North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gottlit Mauch</u>				14. MOTHER'S MAIDEN NAME <u>Frieda Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charles Kinslow - 217 Devonshire Rd - Hagerstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma uterus</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>				24a. REC'D BY REGISTRAR <u>June 5, 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport, R #1</b>				c. LENGTH OF STAY IN TB <b>4 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Church Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/Williamsport, R #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Le Van</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1858</b>	9. AGE (In years last birthday) <b>99</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retird</b>		11. BIRTHPLACE (State or foreign country) <b>Pricetown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Le Van</b>				14. MOTHER'S MAIDEN NAME <b>Magdalena Schmehl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Homewood Church Home Records,</b> Address <b>near Williamsport Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>senary arteriosclerosis</b> (c) <b>linility</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.	Month <b>6</b>	Day <b>17</b>	Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown Md</b>	(County) (State)
21. I certify that I attended the deceased from <b>3-1-</b> , 1957, to <b>6-17-</b> , 1957, that I last saw the deceased alive on <b>6-15-</b> , 1957, and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. E. W. Dittus Jr</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dittus Jr</b>				DATE SIGNED <b>6-17-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Kriders Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Westminster MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Md.</b>			
24a. REC'D BY REGISTRAR <b>JUN 19 1957</b>				24b. REGISTRAR'S SIGNATURE <b>ES Mc Elroy</b>			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
William Howard		45		Male		White		June 19, 1957		Home		Heart Disease		Natural	
Residence		Occupation		Education		Marital Status		Date of Birth		Place of Birth		Date of Admission		Date of Discharge	
1234 Main St.		Teacher		High School		Married		June 1, 1912		Maryland		June 1, 1957		June 1, 1957	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Minister		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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6831

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1. PLACE OF DEATH o. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		c. LENGTH OF STAY IN lb		1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington County Hospital		d. STREET ADDRESS		424 Virginia Ave.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year									
LESLIE		KEELEY		LONG				June		19		57											
5. SEX		male		6. COLOR OR RACE		white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		April 21, 1893		9. AGE (In years last birthday)		64 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Proprietor		10b. KIND OF BUSINESS OR INDUSTRY		Restraunt		11. BIRTHPLACE (State or foreign country)		Downsville, Maryland		12. CITIZEN OF WHAT COUNTRY?		U.S.A.									
13. FATHER'S NAME		Isaac S. Long		14. MOTHER'S MAIDEN NAME		E. Estella Hagerman																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		Yes		16. SOCIAL SECURITY NO.		217-32-5119		17. INFORMANT		Mrs. Helen F. Long		Hagerstown, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		163X		DUE TO		Primary Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH		9 mo.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		with metastases to R. adrenal, brain and lumbar vertebra																	
(c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY		Hour		Month		Day		Year		20d. INJURY OCCURRED		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19																							
21. I certify that I attended the deceased from		Sept 17		1956		to		6-19		1957		that I last saw the deceased alive on		6-18-57		1957		and that death occurred at		245X M		from the causes and on the date stated above.	
ACTUAL SIGNATURE		Robert P. Conrad		M.D.		137 W. Washington		DATE SIGNED		6-19-57													
PHYSICIAN'S NAME (Type)		Robert P. Conrad		Hagerstown, Md																			
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		6/22/1957		22c. NAME OF CEMETERY OR CREMATORY		Rest Haven Cemetery		22d. LOCATION (City, town, or county)		Hagerstown, Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE		Suter-Rouzer Funeral Home		ADDRESS		Hagerstown, Maryland		24a. REC'D BY REGISTRAR		June 26, 1957		24b. REGISTRAR'S SIGNATURE		Lester Powers									

**MEDICAL CERTIFICATION**

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1/18/22		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
MARRIED		1948		MOBILE		ALABAMA		UNITED STATES		1948		MOBILE		ALABAMA		UNITED STATES	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		DATE OF GRADUATION		PLACE OF GRADUATION		CITY		STATE	
HIGH SCHOOL		MOBILE		ALABAMA		UNITED STATES		1940		MOBILE		ALABAMA		UNITED STATES		1940	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY		STATE	
BUSINESS		MOBILE		ALABAMA		UNITED STATES		1948		MOBILE		ALABAMA		UNITED STATES		1948	
CAUSE OF DEATH		HEART		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
HEART		MOBILE		ALABAMA		UNITED STATES		1968		MOBILE		ALABAMA		UNITED STATES		1968	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
NATURAL		MOBILE		ALABAMA		UNITED STATES		1968		MOBILE		ALABAMA		UNITED STATES		1968	
SIGNATURE OF PHYSICIAN		DATE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE	
JAMES EARL RAY		1968		MOBILE		ALABAMA		UNITED STATES		1968		MOBILE		ALABAMA		UNITED STATES	
SIGNATURE OF REGISTRAR		DATE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE	
JAMES EARL RAY		1968		MOBILE		ALABAMA		UNITED STATES		1968		MOBILE		ALABAMA		UNITED STATES	

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6832  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>1 MAIN ST.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE JANE LONG</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 12 - 19 57</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-7-1884</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL LONG-NECKER</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>FOSTER O. LONG</u>				Address <u>KEEDYSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolism &amp; infarction</u> <u>466X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>vein thromboses</u> DUE TO (c) <u>several days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1 arteriosclerotic cerebral vascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1956</u> to <u>June</u> 19 <u>57</u> , that I last saw the deceased alive on <u>June 11</u> 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>H.N. Weeks, M.D.</u>				M.D. <u>130 N. Potomac</u>			
PHYSICIAN'S NAME (Type) <u>H.N. WEEKS, M.D.</u>				<u>HAGERSTOWN, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>June 15, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Barth Baewers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF BIRTH COUNTY STATE		MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
DATE OF BIRTH DAY MONTH YEAR		PLACE OF DEATH COUNTY STATE	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		RACE White <input type="checkbox"/> Negro <input type="checkbox"/> Other <input type="checkbox"/>	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF DEATH DAY MONTH YEAR		PLACE OF DEATH COUNTY STATE	
TIME OF DEATH _____		PLACE OF DEATH COUNTY STATE	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF MINISTER OF THE GOSPEL _____	
SIGNATURE OF CLERK _____		SIGNATURE OF JUDGE _____	

BUREAU V. F.

JUN 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Young

6833 CERTIFICATE OF DEATH 06829 302  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Annie</b> Last <b>Long</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1919</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John A. Socks</b>		14. MOTHER'S MAIDEN NAME <b>Roselia E. Shank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mason F. Long</b>		Address <b>Clearspring R#1 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> (c) <b>High Blood Pressure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/14/57</b> 19, to <b>6/15/57</b> 19, that I last saw the deceased alive on <b>6/15/57</b> 19, and that death occurred at <b>3:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Williamsport, Md.</b> DATE SIGNED <b>6/17/57</b> ACTUAL SIGNATURE <b>Dr. Young</b> PHYSICIAN'S NAME (Type) <b>Dr. Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 19, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. H. H.</b>	



RECEIVED

JUN 21 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

Name of Deceased		John A. Scott	
Date of Death		June 18, 1957	
Place of Death		Washington Co. Hospital	
Age		48	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Teacher	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Artery Disease	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		June 21, 1957	
Place of Registration		Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06830

Reg. Dist. No. 302

6834

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Martin Manor Rest Home 1223 Virginia Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MABLE</b> Middle <b>KATHERINE</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin County, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David H. Hollinger</b>				14. MOTHER'S MAIDEN NAME <b>Annie Oellig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev. Harvey J. Martin R #2 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO <b>Carcinoma Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 year</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6-1-57</b> to <b>6-18-57</b> , that I last saw the deceased alive on <b>6-18-57</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. W. Oellig</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>			
PHYSICIAN'S NAME (Type) <b>S. W. Oellig</b>				DATE SIGNED <b>6/19/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 20, 1957</b>			
25. REGISTRAR'S SIGNATURE <b>Wm. C. Hunt &amp; Son</b>				26. REGISTRAR'S SIGNATURE <b>Wm. C. Hunt &amp; Son</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6870

CERTIFICATE OF DEATH

06831

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville P.O.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home No street address</b>				d. STREET ADDRESS <b>At Home No street address</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>REJEAN</b> Last <b>MAUCK</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 6, 1895</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Benjamin F. Shadrach</b>				14. MOTHER'S MAIDEN NAME <b>Emma K. Anthony</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Geo. W. Mauck</b> Address <b>Maugansville, Md. P.O.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 1, 1953</b> , to <b>June 7, 1957</b> , that I last saw the deceased alive on <b>June 7, 1957</b> , and that death occurred at <b>6:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>6-8-57</b> ACTUAL SIGNATURE <b>Robert P. Conrad</b> M.D. <b>Hagerstown, Md.</b> PHYSICIAN'S NAME (Type) <b>Robert P. Conrad M.D.</b> <b>137 West Washington St. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 10, 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>							

CERTIFICATE OF DEATH

0870

<p>1. NAME OF DECEASED                  [Illegible]</p>		<p>2. SEX                  [Illegible]</p>		<p>3. AGE                  [Illegible]</p>	
<p>4. DATE OF DEATH                  [Illegible]</p>		<p>5. TIME OF DEATH                  [Illegible]</p>		<p>6. PLACE OF DEATH                  [Illegible]</p>	
<p>7. CAUSE OF DEATH                  [Illegible]</p>		<p>8. MANNER OF DEATH                  [Illegible]</p>		<p>9. SIGNATURE OF PHYSICIAN                  [Illegible]</p>	
<p>10. SIGNATURE OF REGISTRAR                  [Illegible]</p>		<p>11. SIGNATURE OF WITNESS                  [Illegible]</p>		<p>12. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>13. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>14. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>15. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>16. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>17. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>18. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>19. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>20. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>21. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>22. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>23. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>24. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>25. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>26. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>27. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>28. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>29. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>30. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>31. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>32. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>33. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>34. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>35. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>36. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>37. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>38. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>39. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>40. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>41. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>42. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>43. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>44. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>45. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>46. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>47. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>48. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>49. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>50. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>51. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>52. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>53. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>54. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>55. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>56. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>57. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>58. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>59. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>60. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>61. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>62. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>63. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>64. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>65. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>66. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>67. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>68. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>69. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>70. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>71. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>72. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>73. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>74. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>75. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>76. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>77. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>78. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>79. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>80. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>81. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>82. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>83. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>84. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>85. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>86. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>87. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>88. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>89. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>90. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>91. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>92. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>93. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>94. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>95. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>96. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>97. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>98. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>99. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>100. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>101. SIGNATURE OF DECEASED                  [Illegible]</p>		<p>102. SIGNATURE OF DECEASED                  [Illegible]</p>	

BUREAU V. 8

JUN 12 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hirshman 06832  
Reg. Dist. No. 302

6835

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Boonsboro R # 1</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>BELLE</b> Last <b>MAY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1957</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26 1885</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (State or foreign country) <b>Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Calvin McNamee</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Crawford</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles L. May Boonsboro Md R # 1</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>260X</b> DUE TO <b>General arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Diabetic and arteriosclerotic angina</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>several years</b> <b>several years</b> <b>1 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.1</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Nov 2</b> , 19 <b>49</b> , to <b>June 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 14</b> , 19 <b>57</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 159 W. Washington St., 6/17/57</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>						24a. REC'D BY REGISTRAR <b>June 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank H. Bowers</b>					







6837

CERTIFICATE OF DEATH

06834

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>755 Summit Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A</b> Last <b>McCann</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 11, 1889</b>		9. AGE (In years last birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Antique dealer</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McCann</b>				14. MOTHER'S MAIDEN NAME <b>Mary Doarnberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-3252-38</b>		17. INFORMANT <b>Mrs. Edward Dayhoff</b> Address <b>Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b> <b>153x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of colon</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 31, 1956</b> to <b>June 2, 1957</b> , that I last saw the deceased alive on <b>June 2, 1957</b> , and that death occurred at <b>9:55 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>L. L. Parker</b> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

NAME OF DECEASED JOHN A. HARRIS		SEX Male		DATE OF BIRTH March 11, 1898	
PLACE OF BIRTH Washington, D.C.		OCCUPATION Police Officer		MARITAL STATUS Single	
PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH June 7, 1957		TIME OF DEATH 10:30 AM		PLACE OF INTERMENT Arlington National Cemetery	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF MORTUARY EXAMINER (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. S.

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6838

CERTIFICATE OF DEATH

06835

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>215 N. Locust St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>M</b> Last <b>McLaughlin</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1880</b>
9. AGE (In years lost birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Sayles</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Barger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9811</b>	
17. INFORMANT <b>Mrs. Elizabeth J. Kline</b>		Address <b>215 N. Locust St. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X <b>Arteriosclerosis and hypertension.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 26, 19 57</b> to <b>June 5, 19 57</b> , that I last saw the deceased alive on <b>June 5, 19 57</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b> DATE SIGNED <b>6-6-57</b>			
ACTUAL SIGNATURE <b>R.A. Bell</b>		M.D. <b>119 North Potomac St. Hagerstown, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/8/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 10, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Wm. C. Hunt</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

RECEIVED  
JUN 12 1957  
BUREAU V. S.

6839

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>H</b> Last <b>Middlekauff</b>				4. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1876</b>	9. AGE (In years last birthday) <b>80</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. Co.</b>	
13. FATHER'S NAME <b>William Middlekauff</b>				14. MOTHER'S MAIDEN NAME <b>Lia Jane Horine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-3104</b>		17. INFORMANT Address <b>Mrs. Carl Sheppard Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion (3 attacks)</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis / heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1949</b> to <b>June 1957</b> , that I last saw the deceased alive on <b>June 1957</b> , and that death occurred at <b>1957</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N. Roman</b>		DATE SIGNED <b>19 June 57</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 22, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME Washington		SEX Male	
PLACE OF BIRTH Washington		DATE OF BIRTH 1-1-1910	
PLACE OF DEATH Washington		DATE OF DEATH 1-1-1910	
OCCUPATION Tailor		CAUSE OF DEATH Heart Disease	
MARITAL STATUS Married		MANNER OF DEATH Natural	
NAME OF SPOUSE Mrs. Jane Horine		NAME OF PHYSICIAN Dr. J. W. Franklin	
ADDRESS 1234 Main St., Washington, D.C.		SIGNATURE OF DECEASED (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF WITNESSES (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

RECEIVED  
 JUN 25 1957  
 BUREAU V. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Kohler Dr Stouffer

06837

6840

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chewsville</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MINNIE IDELLA MILLER</b>		4. DATE OF DEATH Month Day Year <b>June 6 1957 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oot 5 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip H. Cline</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Hooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Albert R. Miller</b>		Address <b>chewsville Wash. Co Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>16 days</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>57</b> , to <b>June 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 6</b> , 19 <b>57</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R. S. Stauffer</b> <b>170 W. Washington St</b> <b>R. S. STAUFFER</b> <b>Hagerstown, Ind</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. REC'D BY REGISTRAR <b>June 10 1957</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>	

# CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		RACE [Faint text, possibly "White"]		DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "New York City"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		PLACE OF DEATH [Faint text, possibly "New York City"]		DATE OF DEATH [Faint text, possibly "1957-06-12"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]		DATE OF INTERMENT [Faint text, possibly "1957-06-15"]		TIME OF INTERMENT [Faint text, possibly "11:00 AM"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	

RECEIVED  
 JUN 12 1957  
 BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06839

Reg. Dist. No. **302**

6842

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at home</b>				d. STREET ADDRESS <b>1 40 E. Lincoln Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Alan</b> Last <b>Moffitt</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1956</b>	
				9. AGE (In years last birthday) <b>— yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>	
						IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Kenneth Moffitt</b>				14. MOTHER'S MAIDEN NAME <b>Lyndall Corlies</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Kenneth Moffitt - Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Megacolon</b> <b>759.3</b> DUE TO <b>Hypoplasia of adrenals</b> Conditions, if any, which gave rise to immediate cause (b) <b>mesenteric adenitis</b> (c) <b>atelectasis of lungs</b> DUE TO <b>atelectasis of lungs</b> causes lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>— — —</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				DATE SIGNED <b>6-10-57</b>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hornum, Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 14, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank H. Bowers</b>	

2081302XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06840  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u> Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Washington County Hospital</u>				d. STREET ADDRESS <u>206 West Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Joseph</u> Last <u>Moss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Joseph Moss</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. O'Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-5284</u>		17. INFORMANT <u>Mrs. Lena Moss</u> <u>206 West Main Street</u> <u>Sharpsburg, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Samuel R. Wells M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>June 7, 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. MANNER OF DEATH: [illegible]  
9. SIGNATURE OF EXAMINER: [illegible]  
10. DATE OF EXAMINATION: [illegible]

BUREAU V. S.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6844 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06841

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hoppital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALFORD DENTON MULLENIX		4. DATE OF DEATH Month Day Year June 6, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Restaaurant	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Alfred Mullenix		14. MOTHER'S MAIDEN NAME Hattie Corder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 163-07-8717	
17. INFORMANT Mr. Clyde M. Mullenix		Address Maugansville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary occlusion Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 min.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc., Hagerstown, Md.		24. REC'D BY REGISTRAR June 10, 1957	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

JUN 12 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06842

Reg. Dist. No. 302

6845

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tenn.</u> b. COUNTY <u>Roane</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harriman 79 x-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R. F. D. # 4 Box # 11</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Morris</u> Last <u>Muth</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 18, 1910</u>		9. AGE (In years last birthday) <u>46 yrs.</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce Business</u>		11. BIRTHPLACE (State or foreign country) <u>Allentown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Muth</u>				14. MOTHER'S MAIDEN NAME <u>? Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>207-07-2033</u>		17. INFORMANT <u>Mrs. Tosie Muth</u> Address <u>Harriman, Tenn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>008X Tuberculosis - Inactive?</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Dittmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. Franklin Brown</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Knoxville, Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Brown</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 3, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>			

MEDICAL CERTIFICATION

2

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81

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

RECEIVED  
JUN 12 1957  
BUREAU V. B.

11/1/57

1957



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6871

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06843

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hancock			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Washington Co. Hospital				d. STREET ADDRESS 165 W. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mark Middle Hanner Last Nester				4. DATE OF DEATH Month June Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1903	
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Carroll Co., Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) Carroll Co., Virginia	
13. FATHER'S NAME Isaac Nester				14. MOTHER'S MAIDEN NAME Terry Goad			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 228-03-9903		17. INFORMANT Mrs. Cora Shaw - 165 W. Main St - Hancock, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/57		22c. NAME OF CEMETERY OR CREMATORY Highland Memory Gardens		22d. LOCATION (City, town, or county) (State) Dublin, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hansel J. Shove				ADDRESS Hancock, Md		24a. REC'D BY REGISTRAR June 27, 1957	
						24b. REGISTRAR'S SIGNATURE C. H. K. Powers	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUL 1 1957  
BUREAU V. S.

VS. AISME(5)  
SM 9/55

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE W. Va.		b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Hancock		c. LENGTH OF STAY IN lb 8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Berkley Springs 85x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				First Middle Last William Andrew Patton		4. DATE OF DEATH Month Day Year June 30 19 57	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1920	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sand Mine		11. BIRTHPLACE (State or foreign country) Berkley Springs, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Patton				14. MOTHER'S MAIDEN NAME Blanche V. Hagan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 2 220-09-7280		17. INFORMANT Address Mrs. Claire Shifflett- Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholic narcosis 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour o. m. p. m. NONE 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 2-57	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-57		22c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		22d. LOCATION (City, town, or county) (State) Berkley Springs, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard P. Stone Hancock Md				ADDRESS Hancock Md		24. REC'D BY REGISTRAR DATE July 8, 1957	
24b. REGISTRAR'S SIGNATURE Kearl H. Bowers							

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		CITY		COUNTY		STATE		CITY		COUNTY	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES		TREATMENT		HISTORY OF ALCOHOLIC DRINKING		HISTORY OF TOBACCO SMOKING		HISTORY OF DRUG USE	
FINDINGS AT AUTOPSY		LABORATORY EXAMINATIONS		TOXICOLOGY		BACTERIOLOGY		HISTOLOGY		PATHOLOGY	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		COUNTY		STATE	

BUREAU V. S.

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar print, burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6873

## CERTIFICATE OF DEATH

Reg. Dist. No.

06844 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Clearspring</u>				c. LENGTH OF STAY IN 1b <u>4 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>				d. STREET ADDRESS <u>Greencastle #3</u>			
3. NAME OF DECEASED (Type or print) <u>Nancy First Middle Last Potter</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shady Grove Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Loy</u>				14. MOTHER'S MAIDEN NAME <u>Florence Fitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>174-20-1650</u>		17. INFORMANT <u>Mrs. Robert L. Johnston, Greencastle Pa., #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo. 8 days</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 7, 1957</u> to <u>June 16, 1957</u> , that I last saw the deceased alive on <u>June 16, 1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>6/17/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Gure</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>J. H. Murray</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. Murray</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JUN 18 1957		BOSTON, MASS.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF MINISTER		NAME OF WITNESS		NAME OF SECOND WITNESS	
MARRIED		JUN 10 1954		BOSTON, MASS.		REV. JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		PLACE OF PREVIOUS MARRIAGE		NAME OF MINISTER		NAME OF WITNESS		NAME OF SECOND WITNESS	
NONE		NONE		NONE		NONE		NONE		NONE	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL	
JUN 19 1957		JUN 19 1957		JUN 19 1957		JUN 19 1957		JUN 19 1957		JUN 19 1957	
PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL	
BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.		BOSTON, MASS.	
NAME OF MINISTER		NAME OF MINISTER		NAME OF MINISTER		NAME OF MINISTER		NAME OF MINISTER		NAME OF MINISTER	
REV. JAMES J. JONES		REV. JAMES J. JONES		REV. JAMES J. JONES		REV. JAMES J. JONES		REV. JAMES J. JONES		REV. JAMES J. JONES	
NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	
NAME OF SECOND WITNESS		NAME OF SECOND WITNESS		NAME OF SECOND WITNESS		NAME OF SECOND WITNESS		NAME OF SECOND WITNESS		NAME OF SECOND WITNESS	
JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	

BUREAU V. 3

JUN 19 1957

RECEIVED

**MEDICAL CERTIFICATION**

1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BAMMORRE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
FINDINGS		OPINION		REMARKS		SIGNATURE		DATE		PLACE	

**RECEIVED**  
 JUN 17 1957  
 BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6847 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06846

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home - 431 N. Jonathan St.</u>				d. STREET ADDRESS <u>431 N. Jonathan Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>-</u> Last <u>Pratt</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-2882</u>		17. INFORMANT <u>John Watson - Undertaker- Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>with gangrene toes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO <u>Acute enteritis</u> (c) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>12 hrs</u> <u>30 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>571.1</u> <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				DATE SIGNED <u>June 6 '57</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-7-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anatomical House of Md. Baltimore Md</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr. Hagerstown Md</u>				24. REC'D BY REGISTRAR <u>June 7, 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Shad H. Bowers</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME(5)  
5M 9/55

BUREAU V. S.

1957 10 NOV

RECEIVED



6848

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x3 Funkstown</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>122 S. West Side Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>FRANKLIN</u> Last <u>REECHER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 14, 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Funeral Director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Ringgold, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob Reecher</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Leiter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-09-7177</u>		17. INFORMANT Address <u>Mrs. Clarence Reecher Funkstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Pneumonia</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Arteriosclerotic heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 24, 1957</u> , to <u>June 27, 1957</u> , that I last saw the deceased alive on <u>6-27-1957</u> , and that death occurred at <u>10:07</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u> M.D. <u>PAUL HARRISON</u> 6-28-57				ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>			
PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D., 318 N. Potomac St., Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Benger</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>July 2, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BALTICORE 187

BUREAU V. 2

MIL 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06848

6874

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b>		c. LENGTH OF STAY IN 1b <b>70 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 E. Balto. St.,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Funkstown</b>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>V</b> Last <b>Rhodes</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1873</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Charlestown, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Rohrer</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Eby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>David H. Rhodes</b>		Address <b>Funkstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arterio-sclerosis</b> DUE TO (c) <b>Generalized arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1 -</b> , 19 <b>57</b> , to <b>June 24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>57</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Funkstown Md</b> DATE SIGNED <b>6-25-57</b>	
ACTUAL SIGNATURE <b>SIDNEY ROVENSTEIN</b> M.D.		PHYSICIAN'S NAME (Type) <b>SIDNEY ROVENSTEIN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-26-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24. REC'D BY REGISTRAR <b>June 27 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shelley C. Bowers</b>	

BUREAU V. S.

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6849

## CERTIFICATE OF DEATH

06849

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>11 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1401 Potomac Ave</b>				d. STREET ADDRESS <b>1401 Potomac Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b>		Middle -----		Last <b>RIDENOUR Sr</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 29 1891</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinery</b>		11. BIRTHPLACE (State or foreign country) <b>Lantz Fred Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Washington Ridenour</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Ambrose</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8743</b>		17. INFORMANT Address <b>Mrs M. Viola Ridenour 1401 Potomac Ave Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 28, 1957</b> , to <b>June 28, 1957</b> , that I last saw the deceased alive on <b>June 28, 1957</b> and that death occurred at <b>2:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b> DATE SIGNED <b>June 30, 1957</b> ACTUAL SIGNATURE <b>R. A. Bell</b> M.D. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. 60 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>July 2, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>			



1401 Polio-V

**BUREAU V. B.**

JUL 5 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06850

6850

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>45 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>323 Frederick St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>323 Frederick St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALTER</b> Middle <b>P</b> Last <b>RITZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 19, 1887</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Organ Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pipe Organ Works</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-4165</b>	
17. INFORMANT <b>Melvin Ritz</b>		Address <b>323 Frederick St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>443X</b> (b) <b>Adenocarcinoma of stomach with generalized metastasis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardio-vascular disease.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>12 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>June 26</b> , 19 <b>56</b> , to <b>June 25</b> , 19 <b>57</b> that I last saw the deceased alive on <b>June 22</b> , 19 <b>57</b> , and that death occurred at <b>1 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John H. Kehne</b> M.D. <b>131 W. Washington St.</b> <b>6/26/57</b> PHYSICIAN'S NAME (Type) <b>John H. Kehne</b> M.D. <b>131 W. Washington St. Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown (Halfway) Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b> <b>Wm. G. Hunt</b> J. Pres.		24. REC'D BY REGISTRAR <b>June 27, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Brown</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>	
<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>		<p>DATE OF ENTRY INTO STATE</p>	
<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>		<p>DATE OF ENTRY INTO STATE</p>	

RECEIVED  
JUL 1 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6851  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

06851

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock Md. 01X22</u>	
c. LENGTH OF STAY IN 1b <u>10 Days.</u>		d. STREET ADDRESS <u>Washington County Hospital</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2.1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw Mill Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Wllegany County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Annetta Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-5531</u>	
17. INFORMANT <u>Miss Mary Roberts Clearspring Rural 2.</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23, 1957</u> to <u>June 23, 1957</u> , that I last saw the deceased alive on <u>June 23, 1957</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>159 W. Washington St. 6/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.26.57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Piney Plains Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Little Orleans Allegany Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hance</u>		ADDRESS <u>Hancock Md</u>	
24a. REC'D BY REGISTRAR <u>June 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles C. Cowers</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUL 1 1957

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06853

Reg. Dist. No. 302

6875

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Death Curve</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U S # 40 - Hagerstown, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle 75-X-3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>B.</u> Last <u>Runyon</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Leonard - Spitz Co</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Township, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>David Wetzel</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Weagley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>175-03-1441</u>		17. INFORMANT <u>Mrs. Bessie Weagley - Mother - Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X</u> DUE TO <u>Fractured skull, hemorrhage &amp; shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:00 p.m. June 9 19 57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Near Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>6-10-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munch</u>				ADDRESS <u>Greencastle, Pa.</u>		24. REC'D BY REGISTRAR <u>June 10, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Shast H. Bowers</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
 JUN 19 1957  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6852

## CERTIFICATE OF DEATH

06854

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>				c. LENGTH OF STAY IN TB <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>Pinesburg</b>			
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>Elanor</b> Last <b>Shank</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 8 1889</b>	
9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Near Charlton Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John D. Shank</b>				14. MOTHER'S MAIDEN NAME <b>Cora Gossard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Williamsport Md RFD 1</b> <b>Mr. George L. Shank Pinesburg Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Williamsport Md</b>	
20f. (City or town) (County) (State) <b>Williamsport Md</b>				20g. (City or town) (County) (State) <b>Williamsport Md</b>			
21. I certify that I attended the deceased from <b>6/12/57</b> , 19____, to <b>6/12/57</b> , 19____, that I last saw the deceased alive on <b>6/12/57</b> , 19____, and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Williamsport Md</b> DATE SIGNED <b>6/14/57</b>							
ACTUAL SIGNATURE <b>Ralph F. Young M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Ralph F. Young M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Clearspring Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert A. Wolf Williamsport, Md</b>				24a. REC'D BY REGISTRAR <b>June 18 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Chas H. Boers</b>							

BUREAU V. S.

JUN 20 1957

RECEIVED

6853

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BLANCHE L SHEISS</b>				4. DATE OF DEATH Month Day Year <b>June 3 1957 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 2 1872</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Chewsville Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mayberry G. Freed</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia H. Stouffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Edna G. Brandenburg 122 No Potomac St Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myelocytic leukemia</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8, 1957</b> , to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>10:30 A.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. A. Bell</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>119 North Potomac Street 6-4-57</b>			
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>				<b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leitersburg Wash. con Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>June 6, 1957 [Signature]</b>			



BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6854

CERTIFICATE OF DEATH

06856

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>9 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 MARBERN RD.</b>				e. STREET ADDRESS <b>111 MARBERN RD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM ELMER SNOOK</b>				4. DATE OF DEATH Month Day Year <b>JUNE 5 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/10/1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTAR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE BLDG.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>MAURICE SNOOK</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MORT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-09-9259</b>		17. INFORMANT <b>MRS. RUTH DECKER HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>450.0</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 29, 1955</b> , to <b>June 5, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. L. Packer, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>1145 W. Washington St. Hagerstown, Md.</b>			
DATE SIGNED <b>6-6-57</b>							
PHYSICIAN'S NAME (Type) <b>L. L. Packer, Jr., M.D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CREEK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b> ADDRESS <b>Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 10, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

**BUREAU**

JUN. 12 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6855

## CERTIFICATE OF DEATH

Reg. Dist. No.

06857

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>67 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>108 S. Mulberry</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harvey Clinton Snook</b>				4. DATE OF DEATH Month Day Year <b>June 4 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1890</b>		9. AGE (In years last birthday) yrs. <b>66</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>House Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Maurice Snook</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Mort</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Maude M. Snook Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Infarction</b> (c) <b>3 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 20th, 1946</b> , to <b>June 4th, 1957</b> , that I last saw the deceased alive on <b>June 4th, 1957</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>159 W. Washington St. 6/5/57</b>							
ACTUAL SIGNATURE <b>Philip J. Hirschman</b>			M.D. <b>159 W. Washington St.</b>				
PHYSICIAN'S NAME (Type) <b>Philip J. Hirschman</b>			M.D. <b>159 W. Washington St., Hagerstown, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>June 7-1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H. Howard</b>			

1000 1000 1000

**BUREAU V. S.**

JUN 10 1957

RECEIVED



1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>705 Medway Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Souders</u> Last <u>Souders</u>				4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3.6.1880</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew L Souders</u>				14. MOTHER'S MAIDEN NAME <u>Anna C Easton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-09-7189D</u>			
17. INFORMANT <u>Catherine Unger</u>				Address: <u>Hagerstown Md. 705 Medway Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with myocardial Failure</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5yr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Apr 15</u> , 19 <u>57</u> , to <u>19 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 June</u> , 19 <u>57</u> , and that death occurred at <u>1140 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				M.D. <u>230 N P. Roman</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>			
DATE SIGNED <u>21 June 57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.24.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>				ADDRESS <u>Hancock Md</u>		24a. REC'D BY REGISTRAR <u>June 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BATTLE ONE 18

## CERTIFICATE OF DEATH

**RECEIVED**  
JUN 28 1957  
BUREAU V. 3

6857

## CERTIFICATE OF DEATH

Reg. Dist. No.

06859

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN TB <u>4 DAYS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY - A. SPIELMAN</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 1 - 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 25, 1880</u> 77 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Boonsboro Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Spielman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Souff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Annie Spielman Hagerstown Md. R. 5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Systemic Cardio Vascular Disease</u> DUE TO <u>14 yrs</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/29/57</u> , 19 <u>57</u> , to <u>6.1.57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/31/57</u> , 19 <u>57</u> , and that death occurred at <u>2:08 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stearl Young</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>6.1.57</u>			
PHYSICIAN'S NAME (Type) <u>S. E. A. YOUNG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Boonsboro Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>June 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. MARITAL STATUS		10. COLOR		11. EDUCATION		12. RELIGION		13. SOCIAL CLASS		14. PREVIOUS ILLNESS		15. MEDICAL HISTORY		16. PHYSICIAN'S SIGNATURE	
17. DATE OF DEATH		18. TIME OF DEATH		19. PLACE OF DEATH		20. NAME OF PHYSICIAN		21. SIGNATURE OF PHYSICIAN		22. NAME OF REGISTRAR		23. SIGNATURE OF REGISTRAR		24. NAME OF WITNESS	
25. NAME OF FUNERAL HOME		26. ADDRESS OF FUNERAL HOME		27. PHONE NUMBER OF FUNERAL HOME		28. NAME OF BURIAL PLACE		29. ADDRESS OF BURIAL PLACE		30. PHONE NUMBER OF BURIAL PLACE		31. NAME OF CEMETERY		32. ADDRESS OF CEMETERY	

BUREAU V. S.

JUN 7 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06861

Reg. Dist. No. 302

6858

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>725 Preston Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>BOWSER</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Mixing Business</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Frank Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Hilda P. Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Margaret W. Thomas Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-1-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Roper</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>July 2, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thomas H. Bowers</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. E.

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06862

Reg. Dist. No. 302

6859

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>60 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1710 Sherman Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jacob Eakle Trovinger</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (State or foreign country) <b>Chewsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Trovinger</b>				14. MOTHER'S MAIDEN NAME <b>Susan Eakle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-1532</b>		17. INFORMANT Address <b>Joseph E. Trovinger, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>  <b>Not known</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b> 420.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>9</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> , 19 <b>57</b> to <b>June 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 31</b> , 19 <b>57</b> , and that death occurred at <b>12:40 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>6/3/57</b>							
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		M.D. <b>148 West Washington St., Hagerstown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				ADDRESS		24. REC'D BY REGISTRAR DATE <b>5, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair Bowers</b>			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
JAMES A. JONES		38		Male		White		White		Roman Catholic		Single		Student		Heart Disease		June 2, 1957		Baltimore, Md.		J. A. Jones		J. A. Jones		J. A. Jones	
Place of Birth		Date of Birth		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day	
Baltimore, Md.		June 2, 1957		June 2, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Death		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year	
Baltimore, Md.		June 2, 1957		June 2, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant	
J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones	

BUREAU V. S.

JUN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6876

CERTIFICATE OF DEATH

Reg. Dist. No.

06863

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 N. Penna. Ave.,</b>				d. STREET ADDRESS <b>/ 215 N. Penna. Ave.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Asbury</b> Last <b>Watson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1871</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (State or foreign country) <b>Piney Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John D. Watson</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. McGinnis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Mary E. Watson</b> Address <b>215 N. Penna. Ave., Hancock, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Congestive Heart Failure</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>434.1</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 15, 1951</b> to <b>June 15, 1957</b> , that I last saw the deceased alive on <b>June 15, 1957</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. E. Tabler</b> M.D.				ADDRESS (Street, city or town, state) <b>Hancock, Md.</b>		DATE SIGNED <b>6/17/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H. E. Tabler</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Piney Plains Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Piney Grove, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> Address <b>Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>June 18, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Kelly</b>	

MEDICAL CERTIFICATION

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BUREAU V. S.

JUN 25 1957

RECEIVED

SA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6877

## CERTIFICATE OF DEATH

06864  
304

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock Md</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural 2 Hancock Maryland.</u> d. STREET ADDRESS <u>Rural 2 Hancock Md.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hester</u> Middle <u>Ann</u> Last <u>Weller</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>30</u> Year <u>19 57</u>																	
<b>5. SEX</b> <u>F.</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9.6.1875</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>9</u></td> <td><u>24</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>9</u>	<u>24</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>9</u>	<u>24</u>																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington County Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>Harris Younker</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Fink</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Roger E Weller Hancock Rural 2</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>422.1</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2mo</u>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. p. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Hancock, Md.</u>		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that I attended the deceased from</b> <u>Apr 20</u> , 19 <u>57</u> , to <u>June 30</u> , 19 <u>57</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.																					
<b>ACTUAL SIGNATURE</b> <u>Ann Shaffer</u> M.D.				<b>ADDRESS</b> (Street, city or town, State) <u>Hancock, Md.</u>				<b>DATE SIGNED</b> <u>7/1/57</u>													
<b>PHYSICIAN'S NAME</b> (Type) _____																					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7.4.57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Stone Bridge Brothorn</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Near Hancock Washington Md.</u>															
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hansel F. Hume Hancock Md</u>				<b>ADDRESS</b> _____		<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>													
<b>DATE</b> <u>7-3</u>																					

MD 380-2114-1-000-10 TO GOVERNMENT CONTRACTORS

JUL 8 1957

RECEIVED

6860

## CERTIFICATE OF DEATH

Reg. Dist. No.

06865

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>43 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>63 North Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Trevor Wilson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1879</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. Bldgs Bridges Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Cleveland Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>Cleveland Ohio</b>	
13. FATHER'S NAME <b>William Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baines</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-7260</b>	
17. INFORMANT <b>Mrs. Ida Wilson</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary Occlusion &amp; Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO <b>Disease</b> (c) <b>Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11.21.49</b> , 19____, to____, 19____, that I last saw the deceased alive on <b>6/26/57</b> , 19____, and that death occurred at <b>11:07 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Scott Young</b>		ADDRESS (Street, city or town, state) <b>145 M. Paterson St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. S. Earl Young</b>		DATE SIGNED <b>6/27/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-28-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>June 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Black H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		JAN 1 1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		TENTH OF DEATH		HUNDREDTH OF DEATH		THOUSANDTH OF DEATH	
JUL 1 1957		10:00 AM		10:00		00		00		00		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
JUL 1 1957  
BUREAU V. S.

CERTIFICATE OF DEATH

6861

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Home</u>				d. STREET ADDRESS <u>412 Brookline Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>THOMAS</u> Last <u>YOUNG</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Building Contractor Own Business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry O. Young</u>				14. MOTHER'S MAIDEN NAME <u>Naomi E. Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. B. F. Franklin Young</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease and cerebral arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>March 22, 1957</u> to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				ADDRESS (Street, city or town, state) <u>148 West Washington St.</u>			
DATE SIGNED <u>6/21/57</u>							
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Young</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>June 26, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>B. B. Kneisley</u>			



BUREAU V. S.

JUN. 28 1957

RECEIVED